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Part 1: Introduction

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What is Our Vision?

- Domestic violence, sexual assault, and stalking are all-too-common experiences for women and teens who are pregnant or have recently given birth.
- The goal of these guidelines is to present an integrated, multidisciplinary approach to service delivery in order to meet the needs of pregnant and parenting survivors of these forms of victimization.

How to Use These Guidelines

Professionals working with pregnant and newly parenting teens and women can benefit from practical information for addressing the issues of intimate partner violence and reproductive and sexual coercion. This first section of these guidelines gives the reader an overview and some context around how the guidelines were developed. The next three chapters—*Trauma-Informed Services for Pregnant and Parenting Survivors, Reproductive Health Effects, and Guidelines for Working With Teens*—are relevant to all disciplines, and serve as the foundation for the discipline-specific guidelines that follow. The next several chapters, Part 5 through Part 8, offer guidelines for health care professionals, community-based and Tribal domestic violence and sexual assault advocates, law enforcement, and prosecutors and system-based advocates. While readers may wish to focus on the chapter for their professional group, reading all of the discipline-specific chapters will help give the "big picture" and facilitate collaboration with other fields.

We list the Practice Guidelines themselves, which are actions to enhance services, at the beginning of each relevant chapter. The material that follows includes the rationale for the guidelines, supporting information, and sample "scripts" or scenarios that bring the guidelines to life. Not every practice guideline will fit every situation; professionals and programs should select the guidelines that apply to the survivors they serve as well as the structure and values of their organizations.

Abuse Dynamics and Implications

The abuse faced by pregnant and parenting women and teens is complex and challenging. This abuse is generally embedded in a pattern of power and control exerted by an abusive partner, rather than manifesting as isolated incidents or victimization by strangers. This pattern of abuse colors the survivor's decision-making. Abusers are experts in using tactics that take advantage of survivors' vulnerabilities and lack of resources. Survivors face an intricate mosaic of risks that makes every decision difficult. A well-meaning professional who does not understand this pattern may believe, for example, that simply leaving her partner will ensure the safety of a young woman and her baby. The survivor, however, may have a more realistic view of her risks: heightened risk of violence (and even death) at the time of separation, financial difficulties, abandonment by friends and family, loss of housing, and the challenges of single parenthood.

Abusers leverage this lack of resources to maintain control; the antidote is to develop a richer variety of community services and supports, to offer more choices to survivors, and to ensure that pregnant and parenting women and teens are not turned off by the very professionals who can offer help. This requires a safety net of services in every community, trauma-informed services from all service providers, and compassionate survivor-centered approaches to outreach and intervention.

Even when survivors are no longer in contact with their abusers, their reactions to the trauma of abuse may affect their ability to receive appropriate services and to navigate the experiences of childbirth and early parenting. While survivors can be remarkably resilient, trauma-informed professionals can support a survivor's efforts to have a healthy pregnancy, a positive childbirth experience, and a rewarding relationship with her baby.

Where are the Survivors?

How, then, could we improve survivors' ability to obtain trauma-informed services and to learn about the availability of advocacy services? We realized that the vast majority of women and teens who are pregnant or have recently given birth are involved with the reproductive health care system. They see obstetricians, gynecologists, nurse-midwives, and other clinicians who care for them during pregnancy, childbirth, and early parenting. They seek family planning services for a variety of reasons.

Because survivors may have contact with only one group of service professionals – health care providers, victim advocates, law enforcement officers, or prosecutors – we believe that it is critical to create a "safety net" of informed professionals in all disciplines. No matter where a pregnant or parenting survivor initially seeks help, each service provider should be prepared to offer information and referrals that will link necessary resources and make it easier for the survivor to navigate service systems.

Addressing the Gaps

The Washington State domestic violence and sexual assault coalitions actively work to identify gaps in systems and services that affect survivors. Community-level service providers need a shared awareness of problems, informed by the voices of survivors, and they need to work together toward solutions. We must address abuse during pregnancy and early parenting, yet the very nature of that abuse makes it difficult for survivors to access services. Abusers use isolation and monitoring of activities as forms of coercive control over their partners (Stark, 2009). Survivors often do not define what is happening to them as abuse or assault, particularly when it occurs during ongoing relationships.

Based on our advocacy programs' experience in working with survivors over the years, the Coalitions identified the gaps in service provision faced by pregnant and parenting survivors: access to services, trauma-informed services from professionals in various disciplines, and a coordinated system of interventions and referrals. We realized that a clear set of practice guidelines could help to address these issues. Building on our state's history of collaborative, multidisciplinary approaches, project partners recruited knowledgeable professionals from across the state to serve on a workgroup to develop the guidelines.

Professionals who work with pregnant and parenting women and teens have an essential role in discussing healthy, consensual, and safe relationships with all clients. Our goal of coordinated and integrated care, as represented by these Practice Guidelines, will enhance survivors' sense of safety and autonomy and increase the efficacy of interventions by service providers.

Incorporating Advances in Service Delivery

We encountered some remarkable new work by Futures Without Violence (formerly Family Violence Prevention Fund) that invited reproductive health care providers to learn about various forms of abuse – intimate partner violence, sexual coercion and assault, and reproductive coercion – and to link up with advocacy programs in their communities. Futures Without Violence worked with us to adapt for our purposes their innovative model for coordinated care entitled *Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive and Sexual Coercion.* Dr. Elizabeth Miller, in combination with Futures Without Violence and other partners, conducted groundbreaking research (Miller et al., 2011) that highlights the need to address specifically all forms of abuse and coercion in the reproductive health setting, with some eye-opening results. Women who received a brief intervention centered on health care providers giving them a safety card were significantly more likely to leave a partner because the relationship was unhealthy or they felt unsafe, compared to women who did not receive the intervention.

The research-informed approach of Futures Without Violence offers a model and some newly defined concepts, such as reproductive coercion, which consists of "birth control sabotage" as well as pregnancy pressure and coercion. (These concepts are defined below.) These controlling behaviors affect reproductive health and are linked to rapid repeat pregnancies, which may further entrap a woman or teen in a relationship with an abusive partner. Because these forms of abuse often overlap with domestic violence and sexual assault, and because health care providers can address them with practical, collaborative interventions, we knew we needed to include this work in our project. These nationally-recognized innovative tools and materials are endorsed by the American College of Obstetricians and Gynecologists (Chamberlain & Levenson, 2012).

The development of these Practice Guidelines allowed us the opportunity to learn about contemporary national developments through an informal literature review and our contact with Futures Without Violence, and to synthesize all the resources available to us into practical, useful suggestions that will enhance services for survivors.

A Paradigm Shift: "Don't Ask, Just Tell!"

A transformative idea that emerged from this project was the "Don't Ask, Just Tell" approach. During the course of the project, this approach evolved as a response to the hesitancy of domestic violence and sexual assault advocates and health care providers to ask direct questions about reproductive and sexual coercion before there was an opportunity to develop rapport with an individual. This approach built upon the brilliantly simple Safety Card intervention developed by Futures Without Violence (FWV). They created a series of attractive, easy-to-read fold-out cards that contained essential information about "how your relationship affects your health." Health care practitioners were trained to use the card to briefly inform patients during regular medical appointments. For health care providers, the idea was to switch the focus from a traditional screening approach, which seeks to uncover information about the patient, to an educational approach, which offers information that may be beneficial to a wide variety of people and opens the door to further communication. This evidence-based intervention had surprisingly powerful results:

> A brief intervention was associated with a 70 percent reduction in the odds of male partner pregnancy coercion among women who recently had experienced intimate partner violence. Study participants who were asked about reproductive coercion and then counseled about harm-reduction strategies — including switching to longer-acting contraceptives and contacting domestic and sexual-assault resources — were also 60 percent more likely to report ending a relationship because it felt unsafe or unhealthy (Futures Without Violence, 2010).

The "Don't Ask, Just Tell" approach has several advantages over a traditional screening that seeks to have individuals disclose whether or not they are experiencing abuse. Domestic violence and sexual assault advocates involved in the project discovered that they could offer critical information about the availability of emergency contraception and pregnancy tests in a timely manner without having to ask sensitive questions requesting disclosure about reproductive and sexual coercion early in the advocacy relationship. Survivors have legitimate concerns about disclosure, ranging from retaliation if the abuser finds out to a loss of privacy and risk of humiliation in their interactions with professionals. Since many survivors are focused on other priorities when seeking services, the Safety Card intervention provides critical information without requiring disclosure from survivors. In addition, in the health care setting, offering this information routinely allows people to use it when they need it; they may not be ready to address abuse, or may need the information for a future relationship.

The "Don't Ask, Just Tell" approach also removes gatekeeping barriers. Since the information is offered across the board, not just to individuals who might be perceived as high risk, teens and women who might never be perceived as in coercive relationships can safely learn about resources. We know that most people in abusive relationships never make it through the doors of an advocacy agency; they are more likely to turn to friends or family than to formal service providers for help. When a woman or teen is given a Safety Card and some useful information during a routine medical appointment, for example, she is then better prepared to help a friend who tells her about experiencing abuse.

Within this project, this approach translated into practical actions such as:

- Community-based advocacy programs began to routinely incorporate information about reproductive coercion, emergency contraception, and pregnancy tests in their intake or early advocacy sessions with clients, including handing out the FWV Safety Card.

- Community-based advocacy programs began to routinely incorporate information about reproductive coercion and birth control that is less detectable by an abusive partner into ongoing conversations with survivors, such as during support group, individual advocacy, and safety planning.

- Health care providers began to use the Safety Card intervention with patients on a routine basis.

- Other professionals involved in this project provided Safety Cards, posters, and handouts in their offices to let people know that they could discuss reproductive health or coercion issues and obtain referrals.

- Law enforcement included the Safety Cards in the packet of information offered to domestic violence victims at the scene of an incident.

Terminology Considerations

Victim, Survivor, Patient, or Client?

Each profession has its own terms to describe the people it serves. In these guidelines, we generally use the terms preferred by the specific discipline we are addressing. For example, we use the term "victim" for the law enforcement and prosecutor guidelines, while using either "survivor" or "client" in the advocacy guidelines. We chose to say "client" rather than "patient" in the health care guidelines, because it seemed to fit a wider variety of settings, including health education and mental health programs.

Broad Definitions

One of the challenges in the field of family violence research has been a lack of standardized definitions. The National Consensus Guidelines (Family Violence Prevention Fund, 2004) provide a working definition for intimate partner violence (IPV), also known as domestic violence (DV). Developed in collaboration with national experts and approved by the Agency for Health Care Research, the Consensus Guidelines are widely accepted in research and practice. Although adolescent relationship abuse (also known as dating violence) is included in the definition of IPV, experts in the field have noted that while many aspects of adolescent relationship abuse are similar to IPV, there are also distinct characteristics relative to the age of the victim and/or perpetrator and different patterns of abusive behaviors. For this reason, a definition for adolescent relationship abuse is included below.

Intimate Partner Violence

Intimate partner violence is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, with the goal of establishing control by one partner over the other. This term applies to heterosexual and lesbian, gay, bisexual, transgendered, queer/questioning (LGBTQ) relationships.

Adolescent Relationship Abuse

Adolescent relationship abuse refers to a pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person within a relationship (including dating), where one or both partners is a minor. This term applies to heterosexual and LGBTQ relationships. Similar to adult IPV, the emphasis on repeated controlling and abusive behaviors distinguishes relationship abuse from isolated events (such as a single experience of sexual assault occurring at a party where two people did not know each other). Sexual and physical assaults occur in the context of relationship abuse, but the defining characteristic is a repetitive pattern of behaviors that aim to maintain power and control in a relationship. For adolescents, such behaviors include monitoring cell phone usage, telling a partner what she/he can wear, controlling whether the partner goes to school that day, as well as manipulating contraceptive use.

Sexual Coercion

Sexual coercion involves a range of behaviors that may include coercing a partner to have unwanted sex, to forcing a partner to have sex against his or her will, to interfering with a partner's choice to practice safer sex. Sexual coercion may involve verbal pressure without threats of harm, threatening with physical injury, physically restraining, holding down, inflicting injuries, or giving alcohol or drugs to incapacitate a person or impair their judgment. Examples of sexual coercion, which may occur in heterosexual or LGBTQ relationships, include:

- Sexual assault/rape
- Threatening to harm a partner unless he or she agrees to have sex
- Forced noncondom use or not allowing other contraceptive use
- Intentionally exposing a partner to an STI (sexually transmitted infection) or HIV (human immunodeficiency virus)
- Pressure or force to engage in intercourse after giving birth, before being medically cleared, which can contribute to a rapid repeat pregnancy

Working Definitions for Key Terms in these Guidelines

The intersections among IPV, reproductive and sexual coercion, and reproductive health have enhanced our understanding of the dynamics and health effects of abusive adult and teen relationships. This has led to new terminology to describe forms of abuse and controlling behaviors related to reproductive health. For the purposes of these guidelines, we provide working definitions for key terms below.

Reproductive Coercion

Reproductive coercion can be present in LGBTQ and heterosexual relationships. Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health. Examples of reproductive coercion include:

- Explicit attempts to impregnate a partner against that partner's will
- Controlling the outcomes of a pregnancy
- Coercing a partner to engage in unwanted sexual acts
- Forced noncondom use
- Threats or acts of violence if a person doesn't agree to have sex
- Intentionally exposing a partner to a STI/HIV

While these forms of coercion are especially common among people experiencing physical or sexual violence by an intimate partner, they may occur independent of physical or sexual violence in a relationship and expand the continuum of power and control that can occur in an unhealthy relationship. The following definitions are examples of reproductive coercion:

Birth Control Sabotage

Birth control sabotage is active interference with contraceptive methods by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking a condom on purpose
- Not withdrawing when that was the agreed-upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Pregnancy Pressure

Pregnancy pressure involves behaviors intended to pressure a partner to become pregnant when that partner does not wish to be pregnant. These behaviors may be verbal or physical threats or a combination of both. Examples of pregnancy pressure include:

- I'll leave you if you don't get pregnant
- I'll have a baby with someone else if you don't become pregnant
- I'll hurt you if you don't agree to become pregnant

Pregnancy Coercion

Pregnancy coercion involves threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision of whether to terminate or continue a pregnancy. Examples of pregnancy coercion include:

- Forcing a partner to carry to term against that partner's wishes through threats or acts of violence
- Forcing a partner to terminate a pregnancy when the pregnant partner does not want to
- Injuring a pregnant partner in a way that leads to a miscarriage

Pregnancy pressure and coercion can apply to any relationship where one partner is able to get pregnant. For example, an individual in a lesbian relationship may insist that her partner be artificially inseminated to bear a child, using physical or emotional threats to force the issue.

Magnitude of the Problem and Focus

Understanding the Need

An initial step in the development of the Practice Guidelines was to learn from four professional groups: (1) domestic violence and sexual assault advocates, (2) health care providers, (3) law enforcement personnel, and (4) prosecutors and court-based advocates. We conducted a Needs Assessment in order to understand how practitioners in Washington State currently respond to sexual and reproductive coercion, and how the Practice Guidelines could be integrated into current practice. We incorporated key findings from our Needs Assessment interviews and focus groups with representatives of these four disciplines into the Practice Guidelines that follow. For a full report on the Needs Assessment methods and findings, see *Needs Assessment Findings Report, Pregnant and Parenting Women and Teens Project.*

The two main purposes of the Needs Assessment were to:

1. *Inform the development of the Practice Guidelines.* Our intent is that the guidelines will be relevant to practitioners' work and reflect survivors' needs and experiences.

2. *Inform the plan for implementing the Practice Guidelines.* We sought to learn what barriers practitioners see to implementing change and what tools or support they may need to make change.

The Needs Assessment included:

- Focus groups and interviews with practitioners in each demonstration site community within Washington State (Pierce County, Whatcom County, and Adams County)
- A statewide online survey of domestic violence and sexual assault advocates
- Key informant interviews with subject matter experts representing the four disciplines (including members of the Statewide Workgroup and other experts identified by Workgroup members)
- A summary of relevant state and national data
- A review of existing policies and practices for identifying and responding to domestic violence, sexual assault, and reproductive coercion

As part of the Needs Assessment, we conducted an online survey of a statewide sample of domestic violence and sexual assault advocates in order to understand advocates' response to reproductive coercion. An estimated 66% of advocates working in domestic violence and sexual assault programs statewide responded to the survey, representing programs serving all 39 Washington counties. Responses from 378 advocates were included in the data analysis.

It is clear from the survey that the majority of both adult women and teen survivors who seek domestic violence or sexual assault services have experienced sexual abuse by a current or former partner. Only half (50.6%) of the advocates indicated that "most" or "some" adult women had disclosed experiencing reproductive coercion. Even fewer advocates (27.7%) indicated that "most" or "some" teens had disclosed reproductive coercion.

National and Washington State Data

A new research study, the National Intimate Partner and Sexual Violence Survey (Black et al., 2010), studied the prevalence of control of reproductive or sexual health by an intimate partner, and found that:

- Approximately 8.6% (or an estimated 10.3 million) women in the United States reported ever having an intimate partner who tried to get them pregnant when they did not want to, or refused to use a condom.
    - 4.8% reported having had an intimate partner who tried to get them pregnant when the woman did not want to become pregnant
    - 6.7% reported having had an intimate partner who refused to wear a condom

Unintended pregnancy may be linked to abuse. According to a study published in the *American Journal of Preventive Medicine,*

- 40% of abused women reported that their pregnancy was unintended compared to 8% of non-abused women (Hathaway et al., 2000)

In a 2010 survey by the National Domestic Violence Hotline involving more than 3,000 callers, one in four women reported some form of birth control sabotage or pregnancy coercion. The questions asked and the responses are listed below:

1. Has your partner or ex-partner ever told you not to use any birth control (like the pill, shot, ring, etc.)? – 25% said yes.

2. Has your partner or ex-partner ever tried to force or pressure you to become pregnant? – 25% said yes.

3. Has your partner or ex-partner ever taken off the condom during sex so that you would become pregnant? – 16% said yes.

4. Has your partner or ex-partner ever made you have sex without a condom so that you would become pregnant? – 24% said yes.

Research on women in Washington State from 2006-2008 reveals the prevalence of assault and abuse related to pregnancy (Washington State Department of Health, 2010):

- 10% of women reported any abuse by an intimate partner around the time of pregnancy, including physical (5%), psychological (7%), or sexual (2%) abuse.

- Nearly 22% of teens (ages 15-19) report experiencing physical, psychological, or sexual abuse by an intimate partner around the time of pregnancy.

IPV and dating violence are pervasive and persistent problems that have major health implications for women and adolescents.

- Approximately 1 in 4 women have been physically and/or sexually assaulted by a current or former partner (Brieding et al., 2009).

- Almost half (45.9%) of women experiencing physical abuse in a relationship also disclose forced sex by their intimate partner (Campbell & Soeken, 1999).

- Each year, 400,000 adolescents experience serious physical and/or sexual dating violence (Wolitzky-Taylor et al., 2008).

These estimates do not include other forms of victimizations such as psychological abuse, threatening harm, or reproductive coercion. Researchers find much higher prevalence rates in clinical settings.

- Among women enrolled in a large health maintenance organization, 44% reported having experienced physical, sexual, and/or psychological IPV in their lifetime (Thompson et al., 2006).

- Two in five (40%) female adolescent patients seen at urban adolescent clinics had experienced IPV; 21% reported sexual victimization (Miller, 2009).

- Among women seen at family planning clinics, more than half (53%) reported physical or sexual IPV (Miller et al., 2010).

As previously noted, birth control sabotage is limited to heterosexual relationships while pregnancy pressure or pregnancy and sexual coercion may occur in heterosexual, LGBTQ, or mixed-orientation relationships.

- Studies suggest that lesbian and bisexual teens are twice as likely as their heterosexual peers to experience unintended pregnancy. Additionally, young lesbians may attempt to hide their sexual identity through intentional pregnancy (Family Violence Prevention Fund, 1999).

- In a study of transgender and intersex people, 50% of respondents had been raped or assaulted by a romantic partner, though only 62% of these individuals (31% of the total) identified themselves as survivors of domestic violence when asked (Courvant & Cook-Daniels, 1998).